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Patients' experiences of CBT and EMDR as treatments for obsessive-compulsive disorder

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Abstract

Introduction: Obsessive-compulsive disorder (OCD) is usually treated with Cognitive Behavioural Therapy (CBT) based on exposure and response prevention principles; although Eye Movement Desensitisation and Reprocessing (EMDR) has also been proposed as a potentially helpful treatment.

Aim: To investigate patients' experiences of the process and outcome of CBT and EMDR.

Method: We conducted in-depth qualitative interviews with 24 (EMDR = 14; CBT = 10) patients who participated in a randomised controlled trial. Interviews were conducted after the end of therapy, transcribed verbatim and interpreted using thematic analysis.

Results: Three superordinate themes were identified, including (1) common experiences and specific experiences of (2) CBT and (3) EMDR. Common experiences of therapy included difficulties in disclosing OCD problems; perceptions about therapists as approachable and non-judgemental; sudden symptomatic improvements; difficulties in engaging with treatment; general satisfaction with therapy; and viewing OCD as a long-term habit. Some differences between these interventions were also found in patients' understanding of the treatment rationale, their experiences and difficulties with specific treatment procedures.

Conclusions: Common process factors were especially prominent in patients' accounts, though it is possible that these interact with more specific change mechanisms such as desensitisation.

Key words: EMDR; CBT; OCD; thematic analysis; qualitative research

Introduction

Obsessive-compulsive disorder (OCD) is a common mental health problem with a lifetime prevalence of 2–3% in the general population (Kessler et al., 2005). OCD usually arises in adolescence (Heyman et al., 2003) and it follows a chronic and often disabling course if left untreated. OCD is associated with relationship problems (Koran et al., 2000), impairments to daily activities and social functioning (Zohar, 2007), and increased suicidality (Torres et al., 2006). OCD is the 4th most common mental disorder and is one of the top ten most disabling illnesses described by the World Health Organisation in terms of lost income and decreased quality of life (Veale & Willson, 2005). Furthermore, OCD is considered one of the most treatment-resistant mental health problems (Ponniah, Magiati, & Hollon, 2013).

Cognitive Behavioural Therapy (CBT) based on exposure and response prevention (ERP) is a psychological intervention recommended by clinical guidelines for the treatment of OCD (e.g., National Institute for Health and Clinical Excellence, 2005). ERP involves repeated and prolonged exposure to stimuli (i.e., situations, sensations) that trigger obsessive thoughts in the absence of compulsive behaviours (i.e., repetitive checking) that patients use to neutralize intolerable thoughts and emotions (Meyer, 1966). Typically, ERP tasks are applied gradually, based on a hierarchy of difficult situations, and exposure can be done *in vivo* and in imagination (Foa, Yadin, & Lichner, 2012). Repeated exposure tasks enable patients to become desensitized to trigger situations, and the frequency of compulsive behaviours diminishes as patients learn that rituals are unnecessary to feel better or to prevent feared outcomes (Foa et al., 2012). Meta-analyses of controlled trials demonstrate

that CBT is an effective treatment for OCD relative to control conditions (Olatunji et al., 2013; Rosa-Alcázar et al., 2008).

Eye-movement desensitisation and reprocessing (EMDR) has been proposed as a viable treatment for OCD in recent studies. EMDR is a psychological treatment designed to alleviate the distress associated with adverse life experiences to and to bring these to adaptive resolution (Shapiro, 1991). The treatment process involves recalling a disturbing memory whilst engaging in bilateral sensory stimulation, which may include rhythmic eye movements, alternating auditory or tactile stimulation (Shapiro, 1991, 1996). This process is repeated until no further distress is reported and until a desired positive cognition is installed in conjunction with the trauma memory. EMDR is supported by a meta-analytic evidence-base as an effective treatment for post-traumatic stress disorder (Bisson et al., 2007; Davidson & Parker, 2001; Van Etten & Taylor, 1998).

Two recent clinical trials have indicated that EMDR can also be used as an effective treatment for OCD. Nazari et al. (2011) conducted a randomized controlled trial demonstrating that EMDR was more effective than citalopram in alleviating symptoms of OCD after 12 weeks of treatment, although longer-term outcomes were not assessed. In another study, CBT and EMDR treatment models were compared experimentally in a clinical trial involving patients with a diagnosis of OCD (Marsden, Lovell, Blore, Ali, & Delgadillo, 2017). No significant differences in OCD symptoms were found between groups post-treatment or at 6 months follow-up. Although these findings suggest that CBT and EMDR attain comparable outcomes, the study was underpowered to examine patient-treatment interactions. Therefore, these group-level results do not rule out the possibility that some patients may respond better to one of the two treatments. Also, importantly,

even if treatments are comparably effective *for the average patient*, there may be individual differences in terms of acceptability, credibility and adherence. Such qualitative differences could help to inform judgements about the suitability of either treatment in individual cases.

Qualitative process-outcome research is particularly useful to explore patients' experiences of treatment as a complement to quantitative methods (McLeod, 2001). Qualitative interviews are well suited to identify valuable idiographic information such as obstacles to treatment adherence (Gore, Mendoza, & Delgadillo, 2015) or unusual adverse reactions to aspects of treatment that other patients experience as neutral or beneficial (Levy, Glass, Arnkoff, & Gershefski, 1996). To our knowledge, however, no previous studies have qualitatively compared patients' experiences of OCD and EMDR for this condition.

This study presents a qualitative analysis of the treatment experiences of patients who participated in a randomised controlled trial (Marsden et al., 2017). The objectives of this study were (1) to identify common themes in patients' experiences of the process and outcome of psychological interventions for OCD; (2) to identify any differences in the experiences of CBT and EMDR; (3) to generate hypotheses about treatment suitability from the available data.

Method

Design, recruitment and interview process

This was a qualitative study of in-depth semi-structured interviews including 24 patients who took part in a randomised controlled trial. The wider trial participants (N = 55) were all treatment seekers sequentially recruited from

initial assessment interviews and waiting lists in a primary care mental health service in the north of England. Consenting participants that met criteria for OCD based on the structured MINI diagnostic interview (Sheehan, 1998) were randomly allocated to CBT based on ERP principles, or EMDR for OCD. EMDR was delivered following the treatment protocol by Marr (2012), which involves: processing current OCD triggers; installing a future template (imagining successful future action); and processing any past related traumatic events. CBT followed the ERP protocol by Foa, Yadin and Lichner (2012), which involves psychoeducation, (*in vivo* and imaginal) graded exposure and desensitisation to OCD triggers, and the development of a relapse prevention blueprint. Both treatments were standardised to 16 weeks, and were delivered by qualified therapists with experience of the indicated treatment model, who practised under clinical supervision and had specialist training. Exclusion criteria were psychotic or bipolar disorders, substance dependence, current suicidal risk or use of benzodiazepines. The study was approved by an NHS research ethics committee (Ref: 13/YH/0338). Further details about the trial procedures, treatments and methods are reported elsewhere (Marsden et al., 2017).

Participants were invited to take part in qualitative interviews sequentially as they completed (or dropped out of) treatment, following a purposive sampling strategy to balance treatment modalities and completion status. We aimed to recruit a minimum of 20 participants overall. Interviews were carried out after the end of treatment to ensure that the interview did not influence the therapy process. Telephone interviews were mostly scheduled within the first 3 months of treatment completion; they were audio recorded and transcribed verbatim. Two interviewers who were

experienced psychotherapists and members of the research team used a standard interview topic guide.

Study sample

A total of 24 (EMDR = 14; CBT = 10) consenting patients were included in the qualitative study; their characteristics are summarised in Table 1 using descriptive statistics. Overall, qualitative study participants had closely comparable demographic and clinical characteristics to the rest of the sample, except that they attended a higher average number of therapy sessions and had a significantly lower level of OCD symptoms post-treatment.

[Table 1]

Interview topic guide

The topic guide was based on a modified version of the interview schedule used in a previous study of patients' experiences of psychological care (Gore, Mendoza, & Delgadillo, 2015). The semi-structured interview included 9 questions (and standard prompts) designed to elicit patients' views about the treatment procedures, rationale, effects, appraisal of benefits versus difficulties, specific impact on OCD symptoms, overall assessment of therapy, recommendations and any other comments. The complete interview schedule is available in appendix 1.

Data analysis

Anonymised interview transcripts were analysed following the 6 phases of thematic analysis described by Braun and Clarke (2006). Stage one involved

familiarisation with all data and initial note taking. Stage two involved 'open coding' of data through a line-by-line inspection of transcripts. Stage three involved clustering codes into potential themes through constant comparison within and across transcripts. In the fourth stage we generated a thematic map and checked compatibility with individually coded extracts across the dataset. The fifth stage aimed to refine the themes into a coherent narrative structure. Finally, during the sixth stage we selected data extracts to produce a descriptive and theoretical argument consistent with the objectives of the study. The analysis was conducted by two researchers through a constant comparison and peer review approach (Angen, 2000; Creswell, 1998). One of the analysts was a (non-clinical) research assistant and the other was an experienced psychotherapist.

Quality control

Qualitative studies can be limited by a number of sources of bias (Creswell, 1998; Creswell & Miller, 2000); such as selection, recall, and confirmation biases. We adopted several strategies to enhance the rigour of this study including: purposive sampling to include cases across both treatments, including completers and dropouts; the use of a standardised interview schedule; audio-recording and verbatim transcriptions of interviews; thematic analysis conducted by two reviewers and moderated by a third reviewer; identification of atypical responses and experiences that were contrary to the predominant themes.

Results

Several themes emerged from the analysis, organised within three superordinate categories: (1) common experiences of therapy processes and

outcomes; (2) specific experiences of CBT patients; (3) specific experiences of EMDR patients. The thematic analysis is supported by a selection of illustrative quotes; these are linked to citation codes where P = participant, F/M = female / male, C = CBT and E = EMDR.

1. Common experiences of the process and outcomes of therapy

Theme 1a. Difficult disclosures. Several patients reported having difficulties at the beginning of therapy in disclosing their mental health issues or admitting the severity of their problems to the therapist. (P2-F-E: *"I think it was difficult to go through the issues with someone […] once everything's out and in the open it's not difficult, but getting it out there in the first place is quite a hard thing to do"*).

Theme 1b. Normalising initial concerns. Despite some initial difficulties, most patients expressed how being able to speak to a trustworthy independent person helped them to understand and normalize their symptoms. (P16-F-C: *"I found the therapist really helpful in the way he explained things, he used really good language and made me really understand"*). Patients in both treatment groups reported finding "the talking" more helpful than the technical aspects of the therapy, and some stated that it was difficult to no longer have the therapist to speak to when treatment ended.

Theme 1c. Perceptions of therapists. There were many similarities in the way participants perceived and described their therapists; many used adjectives such as brilliant, wonderful, kind, understanding, calm and non-judgemental. Participants' perceptions of the therapist as non-judgemental seemed to enable them to overcome their initial trepidation to discuss their mental health problems (P21-F-C: *"she made me feel like I could tell her*

anything, like a lot of the time I'd feel like if I said stuff I'd be judged about it […] But she didn't make me feel like that at all").

Theme 1d. General difficulties. Some participants reported that general life problems made it difficult to make the most of treatment; for example deteriorations in physical illnesses, inconvenient timing or location of therapy sessions, pressures related to education, employment and housing issues. (P7-F-E: *"so I was going through quite a big change with moving house and looking for a new job; things like that, and I think that instability was almost quite unhelpful during the treatment"*).

Theme 1e. Sudden gains. Some participants reported sudden and considerable improvements in OCD after a specific session. Patients indicated that these improvements were related to specific comments by their therapists, which reframed how they thought about themselves and their condition, and reinforced their plan to resist performing their compulsive behaviours. (P10-F-C: *"the therapist said something really quite poignant to me, which was if you were talking to somebody else who was describing what you do, would you use the same words to describe that person as you use to describe yourself […] that was really key I think that was really kind of like a sort of a pivotal point for me really"*; P17-F-E: *"I kinda told her what I was gonna do, she was like yeah that's what you're gonna do […] having someone kind of enforce it I can't explain it was like magic […] until the very very last session nothing had massively changed […] I walked out that night and it was just like gone"*). One patient who was initially despondent about her condition experienced a sudden improvement when she consciously motivated herself to stop living with OCD.

Theme 1f. Treatment satisfaction. Study participants generally expressed satisfaction with their treatment, having experienced it as helpful,

effective and efficient. (P17-F-E: *"it worked perfectly; it was fast; it was efficient; it was easy; it was perfect"*).

Theme 1g. Treatment effects. Patients in both treatment groups reported improvements in their condition; these were expressed in terms of general improvement of OCD symptoms, improved functioning in previously feared situations, reduced time taken in daily routines and better management or control of symptoms. Improvements were also reported in other areas such as in their anxiety, emotions, thoughts, outlook, positivity, self-esteem, confidence, happiness and ability to talk about their problems. (P6-F-C: *"I couldn't go to work and I couldn't go to like public toilets […] by the end I couldn't imagine not going to work or not using particular toilets*"; P1-F-E: *"to say its life changing is strong but it's certainly thereabouts because it's just given me a completely different outlook"*).

Theme 1h. OCD as a long-term condition. Despite their generally positive appraisal of therapy, the majority of participants still experienced some OCD symptoms after treatment. These ranged from infrequent bouts of anxiety to on-going efforts to work on certain problem areas that they were not yet able to overcome. (P10-F-C: *"I've stopped doing about 50 percent of the actions but I still do the others"*). A small number of participants in each group viewed their residual OCD symptoms as a function of habit rather than psychopathology. (P14-F-E: *"I think I'm still carrying out the habit but I think it's more habit than worry"*). Some participants' reflections about treatment indicated that they thought of OCD as a condition that cannot be cured, only managed, even if the treatment worked well. The contexts in which symptoms reoccur or worsen were elucidated by a few participants who reported having setbacks when they felt stressed, tired or busy. (P16-F-

C: *"there are times when I'm under pressure or I'm stressed out where I do notice them creeping back"*).

2. Specific experiences relating to CBT

Theme 2a. Treatment rationale. The majority of CBT patients were able to articulate their understanding of the treatment rationale. Some patients saw CBT as an effort to re-programme the brain to resist compulsions, to understand, normalize and "re-engineer" thoughts. Other explanations described therapy as a process that involves confronting rather than avoiding things so that anxiety can eventually reduce. (P16-F-C: *"I think it's all about reprogramming your brain to realise you know not always have to give into stuff"*).

Theme 2b. Procedures. Participants described how therapy prompted them to identify their current OCD routines and then they developed and worked through graded exposure hierarchies in a structured way. Many identified having to confront anxiety-provoking situations as part of treatment, and some alluded to a collaborative process of selecting treatment goals or therapeutic targets to work on. (P9-F-C: *"I had to perform certain rituals [...] we moved onto actually placing them in hierarchical order [...] the ones that produce less anxiety at the bottom"*).

Theme 2c. Homework. Many participants mentioned the homework aspect of CBT, which included exposure tasks and completing desensitization charts and worksheets. Some patients felt that using written worksheets helped them to understand the purpose of the treatment and it gave them a structure to plan their exposure tasks. (P6-F-C: *"It was quite nice having a whole week to plan how to not perform compulsions"*). However others found worksheets less helpful, stating that this distracted them from

their practical exposure work and made things harder over time. (P21-F-C: *"I found that quite difficult to remember to fill out because then I was focusing more on the paperwork than doing the exposure"*).

Theme 2d. Follow-up review. A couple of participants described having a follow–up review (booster session) after treatment and finding it useful, creating a secure environment to maintain their gains in the knowledge that they would be able to review their progress with a therapist again. (P11-M-C: *"just knowing that I'll be able to come back and have that whether it's the final conversation or whatever but have that conversation after a good period of time just helps make it again feel like quite a secure environment to work on these things"*).

Theme 2e. Difficulties. Most participants experienced difficulties in their treatment for a variety of reasons. Some found the idea of performing exposures difficult at the beginning of therapy. Others experienced difficulties in performing their exposures later on, as they progressed through their graded hierarchy. (P9-F-C: *"as I went up my hierarchy it just because I became more and more anxious having to not perform my compulsions that was difficult"*). Some participants thought that the sessions were too directive and structured, feeling unable to fully express themselves, thus contributing to one participant's ambivalent feelings towards the therapist and eventual decision to drop out. (P22-M-C: *"she gets to the point but it was kind of a bit too much [...] I felt I couldn't maybe express everything I would have liked to within that hour [...] it made me question if I should pursue it"*).

Theme 2f. Suggestions. When asked if they could think of ways to improve treatment, participants suggested having more sessions, getting more in-depth explanations of their problems and improving the funding of

services to reduce waitlists. (P10-F-C: *"Maybe if it had lasted a bit longer maybe we could have got there in the end"*).

3. Specific experiences relating to EMDR

Theme 3a. Treatment rationale. Half of the participants who accessed EMDR could not recall the name of the intervention and struggled to provide a rationale for the treatment. (P13-F-E: *"I wasn't really sure what I was doing; I was like - why am I doing this?"*). Consistent with this theme, a number of patients expressed surprise when the treatment worked well. Some stated that it was not important to fully understand the rationale for treatment as long as it works. Those who articulated their understanding of EMDR stated that it has an effect on the brain and thought processes such as creating different neural pathways, processing or desensitizing thoughts, or reproducing the way in which the brain works during the rapid eye-movement (REM) phase of sleep. (P24-F-E: *"it sort of processes things like rapid eye movement and the tappers sort of almost mimic that"*).

Theme 3b. Preparation techniques. In describing their experiences of the treatment procedures, many patients discussed the preparation phase and self-soothing techniques, such as working though a "safe place" exercise, the use of "resource figures", distraction techniques, and the "light stream" technique. Some participants stated that these techniques had been helpful to reduce stress and to relax, providing a useful safety net before starting the therapeutic process. (P5-F-E: *"started off looking at the preparatory kind of ground work to make sure that you know I had the sort of tools and sort of safety nets really I think around me before we started the process that was really useful"*).

Theme 3c. Bilateral stimulation. Participants also explained the use of bilateral tactile stimulation, which required them to hold "theratappers" (mild electric stimulation devices) in each hand. Some participants found working with these devices relaxing and enabling of spontaneous recall of relevant memories. (P24-F-E: *"using the tappers and things that just popped into your brain when you were using them I found really crazy and fascinating"*). Other participants found it strange or difficult to apply bilateral stimulation; reporting feeling drowsy, exhausted or nauseous after the sessions. (P19-M-E: *"when the buzzers were going on in your hands and you're feeling, going through your rituals in your head it made me feel sick"*).

Theme 3d. Phases of treatment. The majority of participants made reference to "three phases" focusing on the past present and future, or moving back and forth in time. When discussing the "past phase", some participants described surprise about how their traumatic memories were contributing to their symptoms, and eventually experienced a decoupling of negative feelings and past memories. (P14-F-E: *"now when I think about it it's not as traumatic … It's a memory, and I'm past that kind of thing now, that feeling isn't really associated with the thought"*). Some participants mentioned that the "current phase" was more difficult and less helpful than other phases. Others commented that the "future phase" was helpful and enabled them to work on potential situations that may lead to obsessive thoughts or compulsive behaviours. (P5-F-E: *"finding sort of the key trigger points I needed to work on for the future was really helpful"*).

Theme 3e. Difficulties. A number of difficulties were reported. Some participants could not locate a relevant "OCD trigger memory" and described spending lots of time unsuccessfully trying to locate it, which was perceived as unhelpful and instilled doubts about the treatment. (P23-F-E: *"the*

blockage in my treatment was about me not being able to identify the trigger point […] and yeah we did spend quite a lot of time trying to do that"). A few participants found it difficult to replicate their real-world anxiety in their imagination when recalling their OCD routines in the treatment sessions. Some participants benefitted from improved relaxation during the treatment, but reported deteriorations in OCD "checking behaviours" after concluding therapy. (P3-M-E: *"I had some relaxation benefit whilst I was on the treatment but since I stopped the stress levels have gone up and the checking things has got worse"*).

Theme 3f. Suggestions. When asked if they could think of ways to improve treatment, participants suggested having a choice to use eye movement techniques instead of tactile stimulation, getting a more detailed understanding of the therapy processes and rationale, receiving information and hand-outs to read at home, having access to follow-up sessions after treatment to maintain motivation, and having more direct advice from therapists on how to manage their avoidant and compulsive behaviours. A participant who had previously engaged in CBT thought that a mix of EMDR and CBT could be useful. (P12-F-E: *"I didn't really make the connection and see where it was going to help to, so more on the understanding it, and also the name and the not doing the way the name suggests then* [using tactile stimulation rather than eye-movements], *I read up on it before I went to do it and it was just it was a pretty confusing thing"*).

Discussion

This qualitative study presents insights about patients' experiences of different psychological interventions for OCD. Although there are technical differences in the rationale and procedures underpinning each of these interventions, patients reported several common experiences.

Common experiences of therapy

The most notable common theme related to the role of the therapist in enabling patients to speak about their mental health problems within a supportive and non-judgemental context, to make sense of their experience and to facilitate a process of motivation to change their routines and habits. This process of change is consistent with the common factors literature.

Frank's common factors model, for example, emphasizes the importance of the therapeutic alliance, the creation of hope, the development of new perspectives on one's problems, and the enablement of success experiences (Frank & Frank, 1991). According to the *contextual model*, effective therapy relies on fostering an empathic and therapeutic relationship, providing an explanation for problems and a persuasive rationale for treatment which enhances expectations for improvement, and ultimately promoting functional and healthy changes (Wampold & Imel, 2015). The study participants' initial difficulties in talking about their OCD, their engagement in often difficult procedures and their on-going efforts to manage their health after therapy also mirror Ken Howard's *phase model* of psychotherapy change (Howard, Lueger, Maling, & Martinovich, 1993), which is said to follow three stages of *remoralization*, *remediation* (of acute symptoms) and *rehabilitation* of functioning.

The "sudden gain" experiences described above are most enlightening, especially since each of these participants reported no significant change until these specific break-through moments. These experiences may reflect processes related to reframing and normalizing how the person sees themselves and their condition; resolving ambivalence and increasing motivation to change; forming and reinforcing intentions and plans to make positive changes. These change processes have been described in previous studies. Sudden gains in depression, for example, have been found to be associated with cognitive changes in the preceding session (Tang & DeRubeis, 1999) and it has been shown that sudden gains also occur in therapies other than CBT (Tang, Luborsky, & Andrusyna, 2002). Motivation to change is a well-established predictor of treatment outcomes (Norcross, Krebs, & Prochaska, 2011). Some studies have found that enhancing motivation to change can improve OCD treatment outcomes (Meyer et al., 2010; Simpson et al., 2008), although there are also discrepant findings (Simpson et al., 2010). Furthermore, forming clear *if-then* behavioural plans (*implementation intentions*) is a well-established behaviour change method (Gollwitzer & Sheeran, 2006; Toli, Webb, & Hardy, 2016). ERP is particularly explicit about if-then contingencies in the context of exposure tasks, though it is interesting to note that one EMDR patient spontaneously formed a behavioural intention which was contingently reinforced or "approved" by her therapist (case P17-F-E).

Specific experiences in different models of therapy

We also observed several differences between treatments. A marked difference was that EMDR participants seemed to be less clear about the treatment rationale. Although this plausibly contributed to treatment

dropout in some cases, others persisted with treatment in spite of this and still appeared to hold positive outcome expectancies. Treatment expectations are known to predict treatment adherence and outcomes (Constantino et al., 2011). Wampold has proposed that a persuasive rationale is important to enhance expectations (Wampold & Imel, 2015), though it is possible that some therapists were able to foster hopefulness and positive expectations through early gains in relaxation (as reported by some patients) even if the rationale for EMDR may have not been entirely clear.

Many participants reported experiencing difficulties in treatment. Some difficulties were due to external life problems and physical illnesses, but others were treatment-specific. Several CBT patients reported finding exposure anxiety-provoking and daunting, whereas no such fear-related reports were found in EMDR cases. Interestingly, in prior quantitative analyses, no evidence was found of increased anxiety at the early phases of CBT by comparison to EMDR (Marsden et al., 2017). This may suggest that CBT patients' reported difficulties with anxiety are more to do with their *anticipated* feared consequences of exposure (e.g., within-session arousal). Since such consequences do not materialize after exposure tasks, increasing anxiety levels are not observed in between-session measurements. Nevertheless, it is important to recognise that some patients find ERP difficult to tolerate and unacceptable. Other difficulties related to CBT included some cases where treatment was experienced as too structured and directive or burdensome (particularly completing written homework assignments).

Some difficulties that were specific to EMDR included frustrations about not being able to find relevant traumatic memories, finding it difficult to recreate anxiety levels in-session in a way that reflected actual OCD

trigger situations, and some adverse reactions to the bilateral stimulation procedure in the way of nausea, dizziness or exhaustion. These difficulties could in future form the basis for understanding patient preferences and matching patients to treatments. For example, patients who would find *in vivo* exposure intolerable could be offered EMDR; or patients who struggle to pinpoint a clear precipitating event or trauma memory could be offered CBT.

Limitations

There are some limitations that should be taken into consideration when interpreting these findings. We noted that the participants in this qualitative study attended more treatment sessions and tended to have better outcomes compared to the rest of the clinical trial participants. It is likely that we have interviewed patients who tended to have more optimistic views and better treatment experiences. Nevertheless, the sampling strategy enabled us to interview a considerable number of participants, some of whom dropped out and did not benefit from therapy.

The study design does not enable us to draw firm inferences about change processes; although qualitative studies are helpful to generate hypotheses and particularly to understand patients' perspectives about process and outcomes.

Conclusions

In keeping with the data and patients' self-reported experiences, we have underlined several common aspects of the process and outcomes of psychological care for OCD. This emphasis on common factors, however, does not imply that specific mechanisms of action (e.g., desensitization, reprocessing of relevant memories) are not present or relevant; these were

simply not emphasised by the patients that we interviewed. An important clinical implication is that therapists should attend to and emphasise common factors such as enabling patients to disclose and make sense of disturbing experiences within the context of a supportive and non-judgmental relationship; and enhancing motivation to change. We have also found that the acceptability and tolerability of treatment is largely dependent on how credible the rationale is to each individual. The choice of EMDR or CBT could be determined by the extent to which patients find the rationale for each of these treatments credible or acceptable. We have also learned that treatment does not necessarily have a clear endpoint; instead patients learn to understand and manage OCD as a long-term condition that can be controlled.

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Table 1. Sample characteristics

	Full trial sample N = 55 (100%)	**Qualitative study sample** N = 24 (43.6%)
Demographics		
Females	34 (61.8)	17 (70.8%)
Mean age (SD)	32.04 (12.67)	31.79 (13.13)
Unemployed	23 (41.8)	10 (41.7%)
Ethnicity*		
White British	47 (90.4)	21 (95.5%)
Other	5 (9.6)	1 (4.5%)
Clinical Outcomes		
Pre-treatment YBOCS mean (SD)	25.82 (6.40)	24.50 (5.15)
Post-treatment YBOCS mean (SD)	17.75 (8.69)	14.67 (8.33)
6 month YBOCS mean (SD)	18.09 (9.55)	13.71 (8.30)
Mean treatment sessions (SD)	10.49 (6.18)	13.08 (5.12)
Dropped out of treatment	17 (30.9)	5 (20.8)

CBT = cognitive behavioural therapy; EMDR = eye movement desensitization and reprocessing; YBOCS = Yale-Brown Obsessive Compulsive Scale; * percentages exclude 3 cases with missing data

APPENDIX 1

The ECO Trial: EMDR vs. CBT in OCD
Qualitative Interview Topic Guide

Preliminary orientation to the interview:

- Confirm your name and role as a member of the research team.
- Outline purpose of call: to ask a few questions about your involvement in a study focusing on OCD treatment, it should last approximately half an hour and will help us to learn about psychological therapy.
- Remind the person that s/he provided written consent for us to make contact for this interview prior to starting therapy. Ask if the person is still in agreement to take part in the interview and ask for consent to proceed.
- Ask for consent to audio record the interview, assuring that no personal details will be used and the answers will remain confidential. Let the participant know that you will let her/him know when you have turned the recorded on and when you have turned it off towards the end of the interview. After gaining consent, turn the recorder on and re-confirm consent: "For the recording, can I please confirm that you have provided consent for me to record our interview, in the understanding that your responses will be anonymised?"
- Confirm the number of questions prior to starting the interview.

Interview questions and prompts:

1. Can I confirm which type of treatment you accessed?
   (do you remember the name of the treatment)
2. Can you explain roughly what the treatment involved? The question is mostly about the treatment procedures or tasks.
   (what happened in your therapy sessions, what was the purpose of this?)
3. Did you find any aspects of the treatment helpful?
   (how was this helpful, what effect did this have)
4. Was there anything about the treatment that you found unhelpful or difficult?
   (please explain this, can you tell me more about what made this difficult, what effect did this have)
5. Have you noticed any changes in your OCD symptoms now that you have concluded the treatment?
   (what has changed, what's different compared to the time before accessing therapy)
6. Are you still concerned about any symptoms or problems after the treatment?
7. Overall, how well do you think that the treatment worked for you?
8. Do you think the treatment could be improved in any way? How?
9. Is there anything else you'd like to say about your experience of the therapy you accessed?

End: Confirm you have stopped the recording, thank the participant for their time, ask if they would like to receive a copy of our results via post or email when the study has concluded and make a note of this.